

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be reimbursement for dates of service 7-16-01 through 10-19-01.
- b. The request was received on 7-8-02.

II. EXHIBITS

1. Requestor, Exhibit I:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFAs
 - c. EOBs
 - d. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit II:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution dated
 - b. EOBs
 - c. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. The Commission requested two copies of additional documentation via a Fee Letter (MR116) that was mailed to the Requestor on 7-24-02. The Requestor did not respond per Rule 133.307 (g) (3). Therefore, the Commission could not forward any additional documentation to the Respondent per Rule 133.307 (g) (4). The Respondent's three (3) day response is reflected in Exhibit II of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: Letter dated 6-27-02:
“We are officially notifying the ‘Commission’ that the sender of this package is requesting a ‘Medical Dispute Resolution’ pursuant to Rule 133.307. This rule is applicable because this initial dispute resolution request is being filed after January 1, 2002. Our request is made in the form, format and manner prescribed by the Commission, per Rule 133.307(e).”
2. Respondent: Letter dated 8-2-02:
“I have received a copy of your MR-100 regarding the above-captioned medical dispute. Please be advised that ___ has not received a TWCC-60 medical dispute from the Requestor...At this time, I am unable to respond to the MR-100 as I do not have the information to properly respond.”

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are 7-16-01 through 10-19-01.
2. The Carrier has denied the disputed services as reflected on the EOBs as “N,241 – NOT DOCUMENTED”; “A, 240 – PREAUTHORIZATION NOT OBTAINED”.

A Response to a request for reconsideration dated 6-18-02 indicated:

“We have re-evaluated the submitted documentation and feel that our original review was appropriate. Amount rendered is equal or exceeds the payment required under the Texas Workers’ Compensation Act statutory standard for payment for medical providers. In view of this, we are unable to recommend any additional allowance.”

3. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS	REFERENCE	RATIONALE:
7-16-01	99213	\$50.00	\$-0-	N241	\$ 48.00	Texas Workers' Compensation Act & Rules 133.307 (g) (3) (B); CPT Descriptors	When determining whether or not additional reimbursement is warranted, the Medical Review Division must first determine that the services were rendered as billed. Also, Commission Rule 133.307 (g) (3) (B) requires "a copy of any pertinent medical records or other documents relevant to the fee dispute" be submitted. The Requestor has failed to supply any medical documentation for this dispute. Therefore, no additional reimbursement is recommended.
7-16-01	97032	\$25.00	\$-0-	A240	\$ 22.00		
7-16-01	97035	\$25.00	\$-0-	A240	\$ 22.00		
7-30-01	99213	\$50.00	\$-0-	N241	\$ 48.00		
7-30-01	97032	\$26.00	\$-0-	A240	\$ 22.00		
7-30-01	97035	\$25.00	\$-0-	A240	\$ 22.00		
9-14-01	99213	\$50.00	\$-0-	N241	\$ 48.00		
9-14-01	97032	\$26.00	\$-0-	A240	\$ 22.00		
9-14-01	97035	\$25.00	\$-0-	A240	\$ 22.00		
10-12-01	99213	\$50.00	\$-0-	N241	\$ 48.00		
10-12-01	97032	\$26.00	\$-0-	A240	\$ 22.00		
10-12-01	97035	\$25.00	\$-0-	A240	\$ 22.00		
10-19-01	99213	\$50.00	\$-0-	N241	\$ 48.00		
10-19-01	97032	\$26.00	\$-0-	A240	\$ 22.00		
10-19-01	97124	\$31.00	\$-0-	A240	\$ 28.00		
10-19-01	97261	\$10.00	\$-0-	N241	\$ 8.00		
10-19-01	99242	\$90.00	\$-0-	N241	\$ 90.00		
10-19-01	99243	\$180.00	\$-0-	N241	\$116.00		
Totals		\$790.00	\$-0-				The Requestor is not entitled to reimbursement.

The above Findings and Decision are hereby issued this 5th day of December 2002.

Lesia Lenart
Medical Dispute Resolution Officer
Medical Review Division

LL/ll